APPENDIX M-1

CLAIM PREPARATION AND MAILING INSTRUCTIONS FORM HFS 2210, MEDICAL EQUIPMENT/SUPPLIES INVOICE

Please type all Medical Equipment/Supplies Invoices, if possible, or prepare computer-printed Medical Equipment/Supplies Invoices. Handwritten forms require an extra processing step and may take a little longer to pay, depending on available key entry resources.

Please follow these guidelines in the preparation of claims to assure the most efficient processing by the Department:

- Use capital letters.
- Leave a space between dollars and cents in all amount fields.
- Do not use punctuation or special characters anywhere on the form.
- Do not mark anywhere on the form except in the required information boxes.
- Control number, if used by billing contractors in the preparation of claims for providers, must be entered in the upper left portion of the Provider Invoice in the space immediately below the red elongated arrow and to the right of the "Pica" alignment box. The entry must not extend beyond the center of the page.
- Make certain entries are accurate.
- All dates should be completed in MMDDYY format. This is a six digit entry with no dashes, no slashes or spaces, e.g., Jan. 1, 2001 would be entered as 010101.

When preparing claims on a typewriter:

- To insure that characters are clear and sharp, have your machine serviced and cleaned and the ribbon replaced regularly.
- Use a black (preferably mylar) ribbon.
- When correcting errors, use correction fluid only.
- Make sure that the form is properly aligned by using the alignment boxes at the top of the form.
- Tabs may be set using the guide dots at the top of the form.

Appendix M-1a is a copy of Form HFS 2210, Medical Equipment/Supplies Invoice. The form is designed to allow the billing of multiple patients or of multiple items for one patient on a single form. Instructions for completion of Form HFS 2210 follow in the order entries appear on the form. Mailing instructions follow the claim preparation instructions.

The left hand column of the following instructions identifies mandatory and optional items for form completion as follows:

Required	=	Entry always required.
Optional	=	Entry optional - In some cases failure to include an entry will result in certain assumptions by the Department and will preclude corrections of certain claim errors by the Department.
Conditionally Required	=	Entries which are required based only under certain circumstances. Conditions of the requirement are identified in the instruction text.
Not Required	=	Fields not applicable to the provision of DME services.

ITEM EXPLANATION AND INSTRUCTIONS

Required **1.** **Provider Name** - Enter the provider's name **exactly** as it appears on the Provider Information Sheet.

Required **2.** **Provider Number** - Enter the Provider Number exactly as it appears on the Provider Information Sheet. Use no punctuation or spaces.

Conditionally Required **3.** **Payee** - Enter the one-digit code of the payee to whom payment is to be sent. Payees are coded numerically on the Provider Information Sheet.

If no code is entered here, but the provider has designated more than one potential payee on the Provider Information Sheet, the claim will be rejected.

Required **4.** **Billing Date** - Enter the date the Provider Invoice was prepared. Use MMDDYY format.

Optional **5.** **Provider Reference** - Enter up to 10 numbers or letters used in the provider's accounting system for identification. If this field is completed, the same data will appear on Form HFS 194-M-1, Remittance Advice, returned to the provider.

Optional **6.** **Provider Street** - Enter the street address of the provider's primary office. If the address is entered, the Department will, where possible, correct claims suspended due to provider eligibility errors. If address is not entered, the Department will not attempt corrections.

Optional **7.** **Provider City State Zip** - Enter city, state and zip code of provider. See Item 6 above.

8. **Service Sections** - The form provides five service sections to list the specific items for which reimbursement is being requested. These service sections can be used to bill up to five items for the same patient, or to bill for multiple patients. At least one service section must be completed, as follows:

Required **Recipient Name (First, MI, Last)** - Enter the patient's name exactly as it appears on the MediPlan Card, Temporary MediPlan Card or All Kids Card. Separate the components of the name (first, middle initial, last) in the proper sections of the name field.

Required **Recipient No.** - Enter the nine digit number assigned to the individual as copied from the MediPlan Card, Temporary MediPlan or All Kids Card. Use no punctuation or spaces. Do **not** use the Case Identification Number.

If the Temporary MediPlan Card does not contain the Recipient Identification Number, enter the patient name and birthdate on the Invoice and attach a copy of the Temporary MediPlan Card to the Invoice. The Department will review the claim and determine the correct Recipient Identification Number. See "Mailing Instructions" in this Appendix when a copy of the Temporary MediPlan Card is attached.

Optional **Birthdate** - Enter the month, day and year of birth of the patient as shown on the MediPlan Card, Temporary MediPlan Card or All Kids Card. Use the MMDDYY format.

Conditionally Required	**Accident/Injury** - When applicable, enter one of the following codes to indicate the nature of any accident or injury that necessitated the patient's need for the medical equipment or supplies: 1 - A work-related accident or illness 2 - A motor vehicle accident 3 - Participation in an organized sport or school activity 4 - An act of violence (non-accidental) 5 - An unspecified accident
Not Required	Healthy Kids - Leave blank.
Not Required	Cr. Child - Leave blank.
Conditionally Required	**Delete** - When an error has been made that cannot be corrected enter an "X" to delete the entire service section. Only "X" will be recognized as a valid character; all others will be ignored.
Required	**Primary Diagnosis** - Enter the diagnosis description from the ICD-9-CM manual which describes the condition primarily responsible for the patient's need for the items. When necessary, abbreviate.
Conditionally Required	**Prefix** - When the ICD-9-CM Diagnosis Code has an alphabetic prefix of E or V, enter it here.
Required	**Diag. Code** - Enter the primary diagnosis code exactly as it appears in the ICD-9-CM manual. All characters to the left of the decimal point should be entered to the left of the dividing line. All characters to the right of the decimal point should be entered to the right of the dividing line. Do **not** enter the decimal point.
Required	**Ordering Practitioner Name (First, Last)** - Enter the name of the physician who determined the need for the item dispensed.
Required	**Ordering Practitioner Number** - Enter the ordering physician's state medical license number, UPIN, social security number or the provider number assigned by the Department.
Not Required	Order Number - Leave blank.

=Conditionally Required **Prior Approval** - If the item requires prior approval, enter the Prior Approval Number from Form HFS 3076A, Prior Approval Notification Letter. If this field is completed, it may assist Department staff to resolve prior approval problems that cause the claim to be rejected.

Required **Cat. Serv.** - Enter the appropriate two-digit category of service (COS) code:

41 Medical Equipment or Prosthetic Devices
48 Medical Supplies

The COS code for each item is identified in the reimbursement listings on the Department's website. Refer to Topic M-202 for information on finding the lists on the website or on obtaining paper listings of covered items.

Required **Item** - Enter the appropriate five-digit HCPCS or Department-generated code for the item dispensed. Refer to Topic M-202 for information on obtaining a list of all covered items and codes.

Required **Purchase/Rent** - Enter one purchase/rental code as follows:

For COS 41, Medical Equipment/Prosthetic Devices

1 = Purchase
2 = Rental
3 = Repair
5 = Loaner

For COS 48, Medical Supplies

1 = Purchase

Required **Quantity** - Determine the standard unit for the item, and complete this field based on the amount dispensed, expressed in the standard units defined for this item. The standard unit is generally one (1). Exceptions are identified in the reimbursement listings on the Department's website. Refer to Topic M-202 for information on finding the lists on the website or on obtaining paper listings of covered items.

Required **Date of Service** - Enter the date the service or item was provided to the patient. Use MMDDYY format.

Conditionally Required

TPL Code - If the patient's MediPlan or All Kids Card contains a TPL code, the code is to be entered in this field. If payment was received from a TPL resource that is not listed on the MediPlan or All Kids Card, enter the appropriate TPL code as listed in General Appendix 9. If none of the TPL codes are applicable to the source of payment, enter Code "999" and enter the name of the payment source in Field 9, "Uncoded TPL Name".

If more than one third party made a payment for a particular service or item, list the second company in Field 9, Uncoded TPL Name (and include both dollar amounts in the TPL amount).

If there is no third party health resource shown on the Medical Eligibility Card, no entry is required.

TPL Entries for Spenddown. Refer to Handbook for Providers of Medical Services, Chapter 100 General Policies and Procedures, Topic 113 for a full explanation of Spenddown. If the Spenddown was met on the date of service, the patient may be responsible for the entire charge, or for only a portion or for none of the charge. (The day the Spenddown is met is referred to as Split-Bill Day.)

If the service or item was provided on Split-Bill Day, the patient will present the provider with a Form HFS 2432 (Split Billing Transmittal). When a Form HFS 2432 is received, the TPL portions of Form HFS 2210 should be completed as follows:

- Enter 906 in the TPL Code field.
- Enter 01 in the TPL Status field if there is a patient liability or enter 04 in the TPL Status field if there is no patient liability.
- From the Form HFS 2432, enter the amount from the Less Recipient Liability Amount field in the TPL Amount field on Form HFS 2210. This amount may be $0.00.
- Enter the Date from the bottom of form HFS 2432 in the TPL Date field of Form HFS 2210.
- Attach a copy of the Form HFS 2432 when the Form HFS 2210 is submitted for reimbursement.

If multiple items were supplied to the patient on Split-Bill Day, the TPL fields will need to be completed in each Service Section billed. The patient's Spenddown liability will need to be divided and reported in the TPL Amount field of each Service Section. The amount in the TPL Amount field must not exceed the Department's allowable for the particular item.

Conditionally Required

Status - If a TPL code is shown in the preceding item, a two digit code indicating the disposition of the third party claim must be entered. No entry is required if the TPL code is blank.

The TPL Status Codes are:

01 - TPL Adjudicated - total payment shown: TPL Status Code 01 is to be entered when payment has been received from the patient's third party resource. The amount of payment received **must** be entered in the TPL amount box.

02 - TPL Adjudicated - patient not covered: TPL Status Code 02 is to be entered when the provider is advised by the third party resource that the patient was not insured at the time services were provided.

03 - TPL Adjudicated - services not covered: TPL Status Code 03 is to be entered when the provider is advised by the third party resource that the items or services provided are not covered.

04 - TPL Adjudicated - spenddown met: TPL status code 04 is to be entered when the patient's Form HFS 2432, Split Billing, shows $0.00 liability.

05 - Patient not covered: TPL Status Code 05 is to be entered when the patient informs the provider that the third party resource identified on the MediPlan Card is not in force.

06 - Services not covered: TPL Status Code 06 is to be entered when the provider determines that the identified resource is not applicable to the service provided.

07 - Third Party Adjudication Pending: TPL Status Code 07 may be entered when a claim has been submitted to the third party, 30 days have elapsed since the third party was billed, and reasonable follow-up efforts to obtain payment have failed.

10 - Deductible not met: TPL Status Code 10 is to be entered when the provider has been informed by the third party resource that non-payment of the service was because the deductible was not met.

Conditionally Required

TPL Amount - Enter the amount of payment received from the third party health resource. A dollar amount entry is required if TPL Status Code 01 was entered in the "Status" box.

If there is no TPL code, no entry is required.

Conditionally Required

TPL Date - A TPL date is required when any status code is shown in the TPL Status item. Use the date specified below for the applicable code:

Code	Date to be entered
01	Third Party Adjudication Date
02	Third Party Adjudication Date
03	Third Party Adjudication Date
04	Date from the HFS 2432
05	Date of Service
06	Date of Service
07	Date of Service
10	Third Party Adjudication Date

Required

Provider Charge - Enter the total charge for the Service Section, not deducting any TPL.

Conditionally Required

Repeat - This box appears only in Service Sections 2-5. It may be used when two or more Service Sections are for items supplied to the same patient. When an X is entered in this box, all information in the preceding Service Section will be repeated in the Department's claim system, except Date of Service and the TPL fields.

If the item or items dispensed is identical except for Date of Service, the only entries required are an X in the Repeat box and the new Date of Service. If different items are dispensed to the same patient, entries are also required in any fields that differ from the preceding Service Section.

The Repeat box may not be used following a Service Section that has been deleted.

Conditionally Required	**9.**	**Uncoded TPL Name** - If TPL code 999 was used in any of the completed Service Sections, the name of the third party health resource must be entered in this field.
Conditionally Required	**12.**	**Sect. #** - If more than one third party made a payment for a particular service, enter the Service Section number (1-5) in which that service is reported.
Conditionally Required	**13A**	**TPL Code** - Refer to the instructions for **TPL Code** above.
Conditionally Required	**13B**	**Status** - Refer to the instructions for **Status** above.
Conditionally Required	**13C**	**TPL Amount** - Refer to the instructions for **TPL Amount** above.
Conditionally Required	**13D**	**TPL Date** - Refer to the instructions for **TPL Date** above.
Required	**14.**	**# Sects.** - Enter the number of Service Sections completed on this claim. Use a single digit number only. Do not count Service Sections which have been deleted.
Required	**15.**	**Total Charge** - Enter the sum of all charges submitted on this claim in Service Sections 1-5.
Conditionally Required	**16.**	**Total Deductions** - Enter the sum of all payments received from other sources. If no payment was received, leave blank.
Required	**17.**	**Net Charge** - Enter the difference between Total Charge and Total Deductions.
Required		**Provider Certification, Signature and Date** - After reading the certification statement, the provider must sign the completed form. The signature must be handwritten in black or dark blue ink. A stamped or facsimile signature is not acceptable. Unsigned Invoices will not be accepted by the Department and will be returned to the provider when possible. The signature date is to be entered.

MAILING INSTRUCTIONS

The Medical Equipment/Supplies Invoice is a two-part form. The provider is to submit the original to the Department as indicated below. The pin-feed guide strip should be detached from the sides of continuous feed forms. The copy of the claim is to be retained by the provider.

Routine claims are to be mailed to the Department in pre-addressed mailing envelopes, Form HFS 2247, Provider Invoice Envelope, provided by the Department.

Non-routine claims are to be mailed to the Department in pre-addressed mailing envelope, Form HFS 2248, Special Handling Envelope, which is provided by the Department for this purpose. A non-routine claim is one to which one or more of the following documents are attached:

Form HFS 1411, Temporary MediPlan Card
Any other document

APPENDIX M-1a
Reduced Facsimile of Form HFS 2210, Medical Equipment/Supplies Invoice

MEDICAL EQUIPMENT / SUPPLIES INVOICE
ILLINOIS DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

IHFS Use only

ELITE PICA — TYPEWRITER ALIGNMENT **USE CAPITAL LETTERS ONLY** — ELITE PICA

222

1. Provider Name | 2. Provider Number | 3.Payee | 4. Billing Date | 5. Provider Reference

6. Provider Street | 7. Provider City | State | Zip

Service 8.Sections | Recipient Name, (First, MI, Last) | Recipient Number | Birthdate | Acc./Inj. | H.Kids | Cr.Child | Delete

Diagnosis Description | Prefix | Diag. Code

Ordering Practitioner Name (First, Last) | Ord.Prac.No. | Order Number | Prior Approval

Cat. Serv. | Item | Pur./Rent | Quantity | Date of Service | TPL Code | Status | TPL Amount | TPL Date | Provider Charge

1

Repeat | Recipient Name, (First, MI, Last) | Recipient Number | Birthdate | Acc./Inj. | H.Kids | Cr.Child | Delete

Diagnosis Description | Prefix | Diag. Code

Ordering Practitioner Name (First, Last) | Ord.Prac.No. | Order Number | Prior Approval

Cat. Serv. | Item | Pur./Rent | Quantity | Date of Service | TPL Code | Status | TPL Amount | TPL Date | Provider Charge

2

Note: Center section of form has been removed to enlarge detail. The actual form has 5

Recipient Name, (First, MI, Last) | Recipient Number | Birthdate | Acc./Inj. | H.Kids | Cr.Child | Delete

Diagnosis Description | Prefix | Diag. Code

Ordering Practitioner Name (First, Last) | Ord.Prac.No. | Order Number | Prior Approval

Cat. Serv. | Item | Pur./Rent | Quantity | Date of Service | TPL Code | Status | TPL Amount | TPL Date | Provider Charge

5

9. Uncoded TPL Name | 14.#Sects | 15.Total Charge

12. Sec.# | 13A.TPL Code | 13B.Status | 13C.TPL Amount | 13D.TPL | 16.Total Deductions | 17.Net Charge

My signature certifies that: all entries on this claim are true, accurate and complete; the State's Medical Assistance Program pricing limits will be accepted as payment in full; any payments received from the patient or any other third party will be properly credited or paid to the Illinois Department of Healthcare and Family Services; records necessary to fully disclose the nature and extent of services provided are maintained and will be made available upon request of State and Federal officials responsible for the various aspects of the State's Medical Assistance Program, as provided under Title XIX of the Social Security Act and applicable State statutes; I am duly authorized as a representative of the entity to be reimbursed by this claim; I understand payment is made from State and Federal funds and that any falsification or concealment of material fact may lead to appropriate legal action; in compliance with the Civil Rights Act of 1964, services were provided without discrimination on the grounds of race, color or national origin; and handicapped persons are afforded the rights and considerations specified in Section 504 of the Rehabilitation Act of 1973 and Part 84 of the Code of Federal Regulations.
"Completion mandatory, IL.Rev.Stat., Ch. 23, P.A.Code, penalty non-payment. Form Approved by the Forms Management Center."

IL 478-1105
HFS 2210 (R) - 3 - 94)

Provider Signature | Date

APPENDIX M-1b
CLAIM PREPARATION AND MAILING INSTRUCTIONS
MEDICARE/MEDICAID COMBINATION CLAIMS

Handbook for Providers of Medical Services, Chapter 100 General Policies and Procedures, Topic 120.1 provides general guidance for claim submittal and payment when a patient is covered by both Medicare and Medicaid. These are generally referred to as combination claims. This Appendix provides detailed instructions for coding Medicare claims to facilitate proper consideration for payment of coinsurance and deductibles by the Department.

Coding and Submission of Claims to the Medicare Intermediary or DMERC

Charges for services provided to covered participants who are also eligible for Medicare benefits must be submitted to the Medicare intermediary on Form HCFA 1500. The words "Illinois Department of Healthcare and Family Services" or "IHFS" and the patient's nine digit Recipient Identification Number are to be entered in Field 9a of the Form HCFA 1500. Field 27 must be marked "Yes", indicating the provider will accept assignment.

In most instances, this entry will cause the claim to "cross over", that is, the claim will be forwarded to the Department by the Medicare intermediary or DMERC automatically, without any further action by the provider. This is referred to as a crossover claim. When a claim crosses over, the Explanation of Medicare Benefits (EOMB) will contain a message or code (code MA07) indicating that the claim has been sent to the Department. The claim will appear later on a Department Remittance Advice after it has been adjudicated.

Submission of Claims That Do Not Automatically Cross Over

For consideration of payment of the coinsurance and deductible, the provider must submit the claim directly to the Department when:

- Payment is made by the Medicare intermediary but the EOMB does not show that the claim has been crossed over, or
- When more than 90 days has elapsed since the Medicare payment but the claim has not appeared on a Department Remittance Advice.

Submit a copy of Form HCFA 1500 with a copy of the Medicare EOMB.

Prior to submitting the claim to the Department, the following additional information must be entered on Form HCFA 1500:

- The provider name in Field 33 exactly as it appears on the Provider Information Sheet
- The provider's Medicaid Provider Number in the lower right hand corner of Field 33
- The Recipient Identification Number in Field 9A
- Field 27, marked "yes"
- The one digit provider payee code (if the provider has multiple payees listed on the

Provider Information Sheet) in Field 33 immediately following the Provider Name or Provider Number. Enter the word "payee" between the Provider Name or Provider Number and the one digit payee code.

The disposition of the claim will be reported on the Department's Remittance Advice.

Provider Action on Services Totally Rejected by Medicare

Claims which have been denied by Medicare for which the provider is seeking payment must be submitted on a Form HFS 2210 with a copy of the EOMB attached. If Medicare reconsideration was requested and denied, a copy of the reconsideration decision and any correspondence should also be attached.

The claims, EOMBs and all associated documents should be mailed to:

Illinois Department of Healthcare and Family Services
Attention: DME unit
P.O. Box 19124
Springfield, Il 62794-9124

Refer to Topic M-213.2 for further information.

APPENDIX M-2

PREPARATION AND MAILING INSTRUCTIONS FOR FORM HFS 2240, EQUIPMENT PRIOR APPROVAL REQUEST

Form HFS 2240, Prior Approval Request, must be submitted by the provider for certain specified services in order for the services to qualify for reimbursement. Services requiring prior approval are identified in the reimbursement listings on the Department's website. Refer to Topic M-202 for information on finding the lists on the website or on obtaining paper listings of covered services.

Appendix M-2a contains a facsimile of Form HFS 2240. The form provides space to request up to three items for the same patient.

INSTRUCTIONS FOR COMPLETION

The form is to be typewritten or legibly hand printed. Instructions for completion follow in the order entries appear on the form. Mailing instructions follow the form preparation instructions.

The left hand column of the following instructions identifies mandatory and optional items for form completion as follows:

Required	=	Entry always required. If any required items are left blank, the form will be returned as invalid.
Conditionally Required	=	Entries which are required based on an entry in another field. Conditions of the requirement are identified in the instruction text.
Not Required	=	Fields not applicable; leave blank.

ITEM EXPLANATION AND INSTRUCTIONS

Not Required	1.	Trans Code (Transaction Code) - Leave blank.
Not Required	2.	Prior Approval Number - Leave blank.
Not Required	3.	Case Name - Leave blank. (The case name appears on the front of the card in conjunction with the mailing address.)

Required **4.** **Recipient Name** - Enter the name of the patient for whom the service is requested, exactly as it appears on the MediPlan or All Kids card.

Required **5.** **Recipient Number** - Enter the nine digit Recipient Identification Number assigned to the patient for whom the service is requested. This number is found to the right of the patient's name on the back of the MediPlan or All Kids Card.

Required **6.** **Birthdate** - Enter the patient's birthdate. This is a six-digit field. Entry must be in MMDDYY format, with no commas or dashes. For example, a birthdate of February 3, 2001 would be entered as 020301.

Not Required 7. Inst Set (Institutional Setting) - An entry in this field is made only when the patient resides in a Long Term Care facility.

Enter one of the following codes to identify the arrangement:

H = Long-Term Care Facility
I = Sheltered Care Facility
L = Other Location, e.g., State Hospital

If the patient does not reside in a long term care facility, leave blank.

Not Required 8. Case Number - Leave blank. (This number is found in the primary portion (front) of the card immediately above the case name and mailing address.)

Required **9.** **Recipient Street** - Enter the patient's **current** street address.

Required **10.** **Diagnosis Description** - Enter the written diagnosis which describes the condition primarily responsible for the need for the item being requested. Abbreviate if necessary.

Required **11.** **Recipient City, State, Zip** - Refer to Item 9 above.

Required **12.** **Diagnosis Code** - Enter the ICD-9-CM diagnosis code that corresponds to the diagnosis described in item 10 above.

Required **13.** **Ordering Provider Name** - Enter the name of the physician or other provider who signed the order or prescription recommending that the patient receive the specific medical item.

Required **14.** **Order Prov. No. (Ordering Provider Number)** - Enter the ordering physician's state medical license number, UPIN, social security number or the provider number assigned by the Department.

Not Required	15.	Facility Name - An entry in this field is made only when an entry appears in Item 7 above.
Required	**16.**	**Provider Street** - Enter the address of the ordering provider.
Required	**17.**	**Provider Telephone** - Enter the office telephone number of the provider who ordered the item. This information is helpful in instances where the Department needs additional information in order to make a decision on the request.
Not Required	18.	Facility City - An entry in this field is made only when an entry appears in Items 7 and 15.
Required	**19.**	**Provider City, State, Zip** - Refer to item 16 above.
Required	**20.**	**Supplying Provider Name** - Enter the name of the provider who will provide the service.
Required	**21.**	**Supply Prov. No. (Supplying Provider Number)** - Enter the supplying provider's Provider Number exactly as shown on the Provider Information Sheet. Use no punctuation or spaces.
Required	**22.**	**Provider Street** - Enter the supplying provider's address.
Required	**23.**	**Provider Telephone** - Enter the telephone number of the supplying provider's office. This information is helpful in instances where the Department needs additional information in order to act upon the request.
Required	**24.**	**Provider City, State, Zip** - Refer to item 22 above.
Not Required	25.	Aprv. Authority - Leave blank.
Not Required	26.	Disp Date - Leave blank.
Not Required	27.	Approving Authority Signature - Leave blank.
Not Required	28.	Receipt Date - Leave blank.
Required	**29.**	**SERVICE SECTIONS** - The form provides space to request a maximum of three services. When more than three services are requested, a second form must be completed. Instructions for completion of entry fields contained within a service section follow:
	Required	**Req Item No.** - Enter the five digit HCPCS or Department-generated code which identifies the specific item being requested.

Required **Req Qty (Requested Quantity)** - Enter the number of items to be dispensed in the time period covered by the prior approval request.

Unless the code description in the reimbursement listings on the Department's website indicates differently, all items are to be requested in singular form, rather than package form. For example, when requesting one box of 50 diabetic test strips (item code A4253), the requested quantity should be 50, not one. When requesting one box per month for six months, the requested quantity should be 300.

Refer to Topic M-202 for information on finding the listings on the website or on obtaining paper listings of covered services.

Required **Prov Charge** - Enter the total amount to be charged for the item being requested. If the quantity is larger than one, do not enter the unit price. Enter the total amount to be charged for the quantity being requested.

Required **Cat. Serv.** - Enter the Category of Service (COS) code corresponding to the requested item. Valid codes are:

41 - Medical Equipment/Prosthetic Devices
48 - Medical Supplies

The Provider Information Sheet identifies the COS for which the provider is enrolled with the Department.

Required **Description** - Briefly describe the services or items to be provided. Indicate whether the request is for a purchase, rental or repair. If additional space is needed, provide the information on letterhead paper, identifying the patient by name and Recipient Identification Number.

Conditionally Required **Begin Date** - If an item or service has already been dispensed, enter the date the item or service was provided. If the item or service will not be provided until the prior approval request is granted, leave this item blank.

Not Required All remaining items in each service section are for Department use only. Leave blank.

Optional **30.** **Medical Necessity/Additional Diagnoses** - The supplying provider may use this area to enter additional diagnoses or other medical information.

Even if additional diagnosis codes are entered in this item, the request must still include a physician order and documentation of the medical need for the item or items.

Required **31.** **Supplying Provider Signature** - The form must be signed in ink by the individual who is to provide the service.

Required **32.** **Request Date** - Enter the date the form is signed.

MAILING INSTRUCTIONS

Before mailing, carefully review the request for completeness and accuracy. The top two copies of the signed request, with the physician order and any other documentation of medical necessity attached, are to be mailed to:

Illinois Department of Healthcare and Family Services
Bureau of Comprehensive Health Services
Post Office Box 19124
Springfield, Illinois 62794-9124

The remaining copy may be retained in the provider's records.

A notification of approval or denial of the service(s) will be mailed to the provider and to the patient.

APPENDIX M-2a

Reduced Facsimile of Form HFS 2240, Equipment Prior Approval Request

EQUIPMENT
PRIOR APPROVAL REQUEST

Illinois Department of Healthcare and Family Services

Document Control Number

EEE

1.Trans Code | 2.Prior Approval Number | 3.Case Name

4.Recipient Name (First, MI, Last) | 5.Recipient Number | 6.Birthdate | 7.Inst.Set | 8.Case Number

9.Recipient Street | 10.Diagnosis Description

11.Recipient City | State | Zip | 12.Diagnosis Code

13.Ordering Provider Name | 14.Order Prov.No. | 15. Facility Name

16.Provider Street | 17.Provider Telephone ( ) | 18. Facility City

19.Provider City | State | Zip

20.Supplying Provider Name | 21.Supply Prov.No.

22.Provider Street | 23.Provider Telephone ( )

24.Provider City | State | Zip

25.Aprv.Authority | 26.Disp.Date | 27. Approving Authority Signature | 28.Receipt Date

29.SERVICE SECTIONS

1	Req.Item No.	Req.Qty.	Prov.Charge	Cat.Serv	Description
DISP STATUS	Aprv.Item No.	Aprv.Qty.	Unit Amount	Purchase/Rental	
0=Denied	Total Amount	Begin Date	End Date		Reason For Denial
2	Req.Item No.	Req.Qty.	Prov.Charge	Cat.Serv	Description
DISP STATUS	Aprv.Item No.	Aprv.Qty.	Unit Amount	Purchase/Rental	
0=Denied	Total Amount	Begin Date	End Date		Reason For Denial
3	Req.Item No.	Req.Qty.	Prov.Charge	Cat.Serv	Description
DISP STATU	Aprv.Item No.	Aprv.Qty.	Unit Amount	Purchase/Rental	
0=Denied	Total Amount	Begin Date	End Date		Reason For Denial

30. Medical Necessity/Additional Diagnoses

This is to certify that the information above is true, accurate and complete.

31. Supplying Provider Signature

32Request Date

Completion Mandatory, Ill. Rev. Stat., Ch. 23, P.A. Code, penalty non-payment.

HFS 2240 (R-11-91)

IL478-1070

APPENDIX M-3

EXPLANATION OF INFORMATION ON PROVIDER INFORMATION SHEET

The Provider Information Sheet is produced when a provider is enrolled in the Department's Medical Programs. It will also be generated when there is a change or update to the provider record. This sheet will then be mailed to the provider and will serve as a record of all the data that appears on the Provider Data Base.

If, after review, the provider notes that the Provider Information Sheet does not reflect accurate data, the provider is to line out the incorrect information, note the correct information, sign the document and return it to the Provider Participation Unit in Springfield, Illinois. (See Topic M-201.4 for instructions.) If all the information noted on the sheet is correct, the provider is to keep the document and reference it when completing any Department forms.

The following information will appear on the Provider Information Sheet. A sample of a Provider Information Sheet is attached as Appendix M-3a. The item numbers that correspond to the explanations below appear in small circles ◯ on the sample form.

	FIELD	EXPLANATION
(1)	**PROVIDER KEY**	This number uniquely identifies the provider and is to be used as the provider number when billing charges to the Department.
(2)	**PROVIDER NAME AND LOCATION**	This area contains the **NAME AND ADDRESS** of the provider as carried in the Department's records. The three digit **COUNTY** code identifies the county in which the provider maintains his or her **primary** office location. It is also used to identify a state if the provider's primary office location is outside of Illinois. The **TELEPHONE NUMBER** is the primary telephone number of the provider's primary office.
(3)	**ENROLLMENT SPECIFICS**	This area contains basic information reflecting the manner in which the provider is enrolled with the Department. **PROVIDER TYPE** is a three-digit code and corresponding narrative which indicates the provider's classification.

ORGANIZATION TYPE is a two-digit code and corresponding narrative indicating the legal structure of the environment in which the provider primarily performs services. The possible codes are:

01 = Individual Practice
02 = Partnership
03 = Corporation

ENROLLMENT STATUS is a one-digit code and corresponding narrative which indicates whether or not the provider is currently an active participant in the Department's Medical Programs. The possible codes are:

B = Active
I = Inactive
N = Non Participating

Disregard the term NOCST if it appears in this item.

Immediately following the enrollment status indicator are the **BEGIN** date indicating when the provider was most recently enrolled in Department's Medical Programs and the **END** date indicating the end of the provider's most current enrollment period. If the provider is still actively enrolled, the word "ACTIVE" will appear in the **END** date field.

EXCEPTION INDICATOR may contain a one-digit code and corresponding narrative indicating that the provider's claims will be reviewed manually prior to payment. The possible codes are:

A = Exception Requested By Audits
C = Citation to Discover Assets
G = Garnishment
S = Exception Requested By Provider Participation Unit
T = Tax Levy

If this item is blank, the provider has no exception.

Immediately following the **EXCEPTION INDICATOR** are the **BEGIN** date indicating the first date when the provider's claims were to be manually reviewed and the **END** date indicating the last date the provider's claims were to be manually reviewed. If the provider has no exception, the date fields will be blank.

AGR (Agreement) indicates whether the provider has a Form HFS 1413, Provider Agreement, on file and the provider is eligible to

submit claims electronically. Possible entries are YES or NO.

(4) **CERTIFICATION/ LICENSE NUMBER** This is a unique number identifying the license issued by a state agency authorizing a provider to practice or conduct business. This entry is followed by the **ENDING** date indicating when the license will expire.

(5) **S.S.#** This is the provider's social security or FEIN number.

(6) **SPECIALTY AND CATEGORIES OF SERVICE** This area identifies special licensure information and the types of services a provider is enrolled to provide.

ELIGIBILITY CATEGORY OF SERVICE contains one or more three-digit codes and corresponding narrative indicating the types of service a provider is authorized to render to patients covered under the Department's Medical Programs. The possible codes are:

041 = Medical Equipment/Prosthetic Devices
048 = Medical Supplies

Each entry is followed by the date that the provider was approved to render services for each category listed.

(7) **PAYEE INFORMATION** This area records the name and address of any persons or entities authorized to receive payments on behalf of the provider. Each potential payee is assigned a single digit **PAYEE CODE**, which is to be used on the claim form to designate the payee to whom the warrant is to be paid.

If no payee number is designated on a claim form, but multiple payees are shown on the Provider Information Sheet, the claim will be rejected.

PAYEE ID NUMBER is a sixteen-digit identification number assigned to each payee to whom warrants may be issued. A portion of this number is used for tax reporting purposes, therefore no payments can be made to a payee unless the number is on file. Immediately following this number is the effective date when payment may be made to each payee on behalf of the provider.

The **MEDICARE/PIN** or the **DMERC** # is the number assigned to the payee by the Medicare Carrier to cross-over Medicare billable services. The **PIN** is the number assigned by Medicare to a provider within a group practice, if applicable.

(8) **SIGNATURE**

The provider is required to affix an original signature when submitting changes to the Department of Healthcare and Family Services.

APPENDIX M-4

AUGMENTATIVE COMMUNICATION DEVICES PRIOR APPROVAL REQUEST GUIDELINES

PHYSICIAN PRESCRIPTION AND CERTIFICATION OF MEDICAL NECESSITY

The augmentative communication device must be prescribed by the patient's primary care physician. Medical necessary must be certified by the primary care physician. The certification must document that:

- The individual lacks the ability to communicate with a physician or principal care giver in a manner sufficient to determine the person's care and treatment needs, to determine whether those needs have been met satisfactorily, to prevent or address an emergency medical need, and to prevent or address real or foreseeable injuries or impairments, and
- That intervention will correct a physical deformity or malfunction, or support a weak or deformed part of the body for the purpose of enhancing the individual's ability to communicate medical needs.

It is not required that the physician specify the type of device, since that will be determined from the assessment report.

ASSESSMENT REPORT

A patient assessment must be performed by a team led by a speech-language pathologist. The team must include the patient's primary care physician and parent (or primary care giver) and other licensed or board-certified medical professionals, as appropriate based on the patient's identified needs.

While there is no prescribed format for the assessment report, it must include the following information as it relates to the patient's ability to communicate:

A. A brief patient demographic and biographic summary including:
   - Diagnosis and reason for referral
   - Age
   - Approximate physical size
   - Living arrangement (with family and size and composition, in a Long Term Care or group facility, in a Supported Living facility, etc.)
   - Primary patient activities (e.g., school and grade level, employment and type, workshop or day treatment, stays at home) and
   - A list of other supportive resource individuals, if any (e.g., family members, friends, aide at school or work, in-home worker, facility staff).

B. An inventory of skill levels, sensory function, and use of assistive devices, if any, in the following areas:
   - Vision
   - Hearing
   - Ambulation mode(s), including seating and positioning, if applicable
   - Functional gross and fine motor skills in head and neck, trunk, and all four extremities
   - Cognition and learning potential, to include:
     - Cause and effect (ability to associate certain behaviors or events with actions that will follow)
     - Object permanence (ability to remember objects and realize they exist when they are not seen)
     - Means end (ability to anticipate events independent of those currently in progress) and
     - Cognitive level to include any available, recent standard or observational measurements of mental and developmental ages, and demonstrated consistent ability to attend, match, categorize, and sequence.

C. An inventory of present and future communication skill levels, to include the following:
   - Type of expressive communication method or mode(s) used
   - Functional level of oral, written and gestural expressive language capabilities, including oral motor speech status, and the communication functions of requesting, protesting, labeling and sharing information
   - Functional level of receptive communication skills, including language comprehension abilities
   - Communicative interest and
   - Identification of a reliable and consistent motor response which can be used independently to communicate.

D. An explanation of present and future communication needs, including the types of communication needed, with whom and in what environments (for example, to enhance conversation or to write and signal emergency, basic care and related medical needs).

E. Features needed in patient communication system, as applicable:
   - Type and number of messages, vocabulary size, coding system, symbol sets, message retrieval
   - Size, layout, system memory, optical indicators, auditory prompts, rate enhancement, programmability, computer compatibility
   - Type of input method (for example, switches, mouth stick, head pointer, alternative keyboard, and direct selection, scanning, encoding)
   - Type of output (for example, speech, print, LCD, braille)

- Mounting and portability
- Extent of training required to use the system and availability of training and technical assistance for its use
- Availability of customer service by manufacturer or supplier and
- Any other relevant considerations.

F. A summary of intervention options, to include:
   - A description of the systems tried by the patient during or prior to the assessment and
   - The advantages, disadvantages, cost, and availability of training and customer service, for the two or three most appropriate communication systems for the patient as determined through the assessment, specifying available features and patient needs for each.

G. Documentation of patient trial and success, including ability, motivation, independence, and improvement in communication effectiveness, in using one or more recommended communication systems, prior to or during the assessment.

H. The final recommendation of which system is most appropriate to meet the patient's medical needs and why.

The request must include documentation of a vendor's price quote, a copy of the warranty, the availability of maintenance, the shipping location, and a recommendation of at least one other system which would meet the patient's medical needs. Department approval will be made based on the most cost effective system that meets the individual's medical needs.

INDIVIDUAL TREATMENT AND IMPLEMENTATION PLAN

The individual treatment and implementation plan shall identify specific actions, objectives, time lines and the individual(s) responsible to carry out the plan, including programming the communication device, providing training in its use, and monitoring and following-up with the patient to assure appropriate utilization and effectiveness of the device to meet the individual's medical needs. The plan shall also identify the number of orientation or training sessions, and the individuals to be trained (for example, the patient, family, support staff, primary care givers) in the programming and operation of the communication device.

In some instances, when there is a doubt about the patient’s ability to use the device that is recommended, the Department may approve rental for a trial period. When a trial period is approved, a follow-up assessment from the therapist will be required if the trial period results in a request for purchase of the device.

REPLACEMENT, MODIFICATIONS OR UPGRADES

Replacement, modification or upgrades of communication devices will require a complete

assessment and will be subject to the Department's prior approval policy. Replacements will be approved only if a device is not repairable, is destroyed or stolen, or no longer meets the individual's medical needs. Technological improvements and upgrades are not considered to be repairs and are subject to prior approval.

APPENDIX M-5
Reduced Facsimile of C-PAP / BIPAP Questionnaire

C-PAP / BIPAP RENTAL REQUEST

_____ _____ _____ ___ Initial

Date Recipient / RIN Treating Physician / Phone

_____ _____ ___Renewal

Designated Person / Phone Sleep Study Physician / Phone

Date of Study:_____ Location of Study: _____

Patient BMI: _____ Patient Age: _____

Study Done With CPAP: __Yes __No If No, attach separate sheet with explanation.

If Yes, Were Apnea and Hypoxemia Alleviated with CPAP?: __Yes __No

For BiPAP Requests

CPAP Trial: ___Yes ___No Length of Trial:_____

Titration and explanation of CPAP failure: _____

_____

BiPAP significantly ameliorated the breathing disorder and was associated with improvement in sleep quality:

___Yes ___No

Documented Presence of Necessary Information for 90 Day Trial Period

Potentially life threatening apnea: ___Yes ___No ___Unknown

Lowest SaO2 without O2: ___ %(minimum of 90% or less) ___unknown

Decrease in number of apneic events: ___Yes ___No ___Unknown

Increased consolidation of slow wave or REM sleep: ___Yes ___No ___Unknown

SaO2 greater than 90% during sleep study: ___Yes ___No ___Unknown

Patient (care giver) exhibits knowledge and desire to use CPAP/BiPAP: ___Yes ___No ___Unknown

Name and Address of Physician responsible for follow-up: _____

_____

_____

_____

Requests following <u>90 Day Trial</u> and <u>Annual Renewals</u> require the following documentation.

A current update report from the physician (either attending physician, monitoring physician or designated person who is supervised by a physician) that includes documentation of relief of symptoms, continued compliance, number of hours used that have been recorded on the equipment, and continued medical necessity.

The provider will notify prescriber when a prescription and supportive information is needed.

Physician Signature (not stamped): _____ Date:_____ (Form 206.2a)

HFS 3701F (N-8-98) IL478-1811

APPENDIX M-6
Reduced Facsimile of Power Wheelchair Questionnaire

QUESTIONNAIRE FOR POWER EQUIPMENT WHEELCHAIR

Date:_____

Patient Name:_____ DOB:_____ Recipient I.D._____

To make a reasonable recommendation as to the medical necessity of the very expensive power equipment requested, our physician consultants need the following documentation from the ordering physician:

1. Age, weight, and height. Estimate weight and height, if necessary.

2. Narrative report of onset and severity of impairment to include:
   a. Complete diagnosis
   b. Upper body control and strength
   c. History of decubitus events and location
   d. Fixation or non use of joints
   e. Any other information that will aid in making an appropriate decision.

3. Physician appraisal of:
   a. Expected activity of the patient in or out of household environment
   b. Hours spent in the appliance daily
   c. Ability to eat, drink, and enter or leave bed
   d. Ability to operate the proposed appliance in or out of living quarters, elevators and in transportation.

This request cannot be considered for approval or denial without this information being presented, dated and signed.

Thank You for your cooperation.

_____
Physician Signature

_____
Date Completed

HFS 3701H (N-11-98) IL478-1861

APPENDIX M-7
Reduced Facsimile of TENS Unit Questionnaire

QUESTIONNAIRE FOR TENS UNIT

Date:_____

Patient Name:_____ DOB:_____ Recipient I.D._____

INDIVIDUAL ANSWERS TO ALL OF THE QUESTIONS ARE REQUIRED FOR RENTAL/PURCHASE CONSIDERATION OF A TENS UNIT

1. Give dates patient had a trial use of the TENS unit.
   Results :
2. Give complete specific medical diagnosis and history.
3. State cause of disability and date of onset.
4. Is disability acute, chronic, progressive, remedial or permanent?
5. List specific locations(s) of pain.
6. To what extent does the disability hinder the patient? If the pain is an occupational disability, describe.
7. List all previous treatments along with length of time each was in use.
8. Since the TENS unit can provide only palliative relief of pain, what is to be the remedial treatment?
9. List all medications and dosages BEFORE the use of TENS unit.
10. List all medications and dosages WITH the use of TENS unit.
11. How often is patient using the TENS unit?
    How many hours per day?
12. Date patient was last seen.
13. Date patient is to return to see you.
14. What is the prognosis?

_____
Physician Signature

_____
Date Completed

HFS 3701E (N-8-98) IL478-1861

APPENDIX M-8
Reduced Facsimile of Decubitus Mattress Questionnaire

SPECIAL DECUBITUS MATTRESS QUESTIONNAIRE

Date:_____

Patient Name:_____ DOB:_____ Recipient I.D._____

INDIVIDUAL ANSWERS TO ALL OF THE QUESTIONS ARE REQUIRED FOR RENTAL CONSIDERATION OF PRESSURE PADS, MATTRESS OVERLAYS, AND/OR AIR FLUIDIZED SYSTEMS... These questions should be answered by the home health agency registered nurse or the attending physician, but ALL of the information must be reviewed and signed by the attending physician. Acceptable is either this form or a narrative format.

****

VENDOR must submit a copy of the sell sheet that includes product/pricing information along with a copy of the invoice for each request.

1. What is the complete diagnosis with complicating factors, e.g., nutrition, mobility, care giver?

2. Does the patient have any decubitus presently? State location and give complete description, e.g., multiple stage II on trunk or pelvis or any stage III or IV.

3. Is the patient presently on a pressure-relief system or been on an ulcer treatment program for at least the last month that has included the use of a non powered pressure reducing overlay/mattress or alternating pressure pad?

4. Has there been any surgical intervention including myocutaneous flap, skin graft, or debridement: If so give the date of surgery. _____

5. Is there currently a treatment plan in place?
   If so, who is carrying out the treatment plan (i.e., nursing agency)? If nursing agency, please submit:

   a. Initial
   b. Education
   c. Weekly clinical assessment
   d. Turning and positioning schedule, if applicable
   e. Appropriate wound care and treatments
   f. Management of incontinence, if applicable
   g. Management of nutrition
   h. Patient/care giver compliance

6. If no improvement, why is patient still on this product? What is the plan of care?

_____
Physician Signature

_____
Date Completed

HFS 3701G (N-8-98) IL478-1861

APPENDIX M-9
Reduced Facsimile of Request for Approval of Orthotic Services

Illinois Department of Healthcare and Family Services

REQUEST FOR APPROVAL FOR ORTHOTIC SERVICES

Patient Name _____ Recipient Number _____

Address (Street) _____ (City) _____

1. Diagnosis: _____

2. Past Treatment Provided For Presenting Condition: _____

3. Past Surgery (Include Type and Date): _____

4. Orthomechanical Device (Include Procedure code and Date): _____

5. Description of Item or Service for Which Approval is Being Requested: _____

6. Medical Necessity/Prognosis: _____

Completion mandatory, Ill. Rev. Stat., Ch.23, P.A. Code, penalty non-payment. Form approved by Forms Management Center.

Provider Name _____ Date _____

HFS 314A (R-5-2000) IL478-1060